

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

May 9, 2002

RE: 053301047

Effective Date of Coverage: 05/07/2002

Dear Mr. Meadows,

We appreciate the confidence you have placed in us. It is our pleasure to accept you for coverage under this benefit plan.

We have enclosed your Coverage(s) of Insurance and ask that you read it carefully. We want you to understand all benefits available to you and your dependents. As you review your Coverage(s) of Insurance, please check the attached Enrollment Application carefully. Are all answers to the questions completely and accurately recorded? If not, please notify us right away. We want your Coverage(s) of Insurance to be properly issued so that when you call upon the benefits provided by it, you can be confident that they will be paid promptly and accurately.

**Based on medical information received, it was necessary for us to attach an Exclusionary Endorsement to your Coverage of Insurance.** Depending on the condition(s), the exclusion may be reconsidered in one year. We will need your written request for consideration of removal, along with such medical evidence as may be available at the time which relates to the excluded condition(s).

To request the reasons for our decision, send your written request to us within ninety (90) days of the date of this letter.

Should you request specific medical information, we may, under law, disclose the information directly to you or your physician. In order to process your request, you must furnish the name and address of the physician who is to receive the medical information. You may ask us to correct, amend or delete any information about you in our files. If we are unable to do so, you may send us a written statement of what you believe to be correct information. The statement will be placed in your file and will be available to anyone reviewing that file.

There are a few items we would like to remind you about:

- For your convenience, your billing amount will include charges for your insurance as well as any optional benefits chosen, and your Association dues, if applicable. Please note the premium for each of the coverage(s) issued is stated on the Schedule Page of the enclosed document(s).
- If you selected automatic bank payment, a draft will be taken from your account approximately every thirty (30) days, starting with the date shown on your Coverage's Schedule Page.
- Your Coverage(s) benefits and/or premiums are based upon your state of residence. If you move, your benefits and/or premiums may change. Please notify us when you move.
- A special claims hotline number has been established for your convenience.      **1-800-527-2845**

Your Coverage(s) of Insurance is an important document. We encourage you to store it in a safe place. If your Coverage(s) of Insurance is misplaced or damaged, we would be happy to replace it for a nominal administrative charge. Please review your Coverage(s) of Insurance carefully and if you have any questions please call our toll-free number listed below. Our Client Services Representatives are waiting to help you with any concerns regarding your coverage, benefits, or billing.

Thank you very much for the opportunity to be of service to you.

Sincerely,



Doug Kornegay

Vice-President of New Business/Underwriting

P.O. Box 982016, North Richland Hills, TX 76182-8016 1-800-527-5504

EXHIBIT E

M E 0 0 0 1 6 5

